



MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS
DIVISION OF OPERATIONS
COMPLAINT INVESTIGATION UNIT



**FACILITY REQUEST TO ACCEPT EVIDENCE OF DEFICIENCY CORRECTION
IN LIEU OF A REVISIT FOLLOWING A COMPLAINT SURVEY**

Facility: _____ CMS Provider Number: _____

Address: _____

Intake Number: MI _____ Survey or Revisit Date: _____

This facility was cited for noncompliance with the following Medicare/Medicaid LTC Regulations on the survey date indicated above:

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

Tag: _____ Scope/Severity: _____ Tag: _____ Scope/Severity: _____

All tags for this abbreviated/complaint survey are at Centers for Medicare and Medicaid Services (CMS) Scope/Severity levels F or below and there has been no finding of substandard quality of care. Under CMS policy, the Michigan Department of Community Health (MDCH)/Bureau of Health Systems (BHS) is not required to perform an onsite revisit to determine correction of these deficiencies. The facility has submitted, and MDCH/BHS has accepted, Plans of Correction for these deficiencies in which specific completion dates were specified by the facility. Attached is evidence to document correction of the deficiencies listed and evidence to establish a quality assurance program to maintain compliance.

By signature below and submission of the attached evidence, the facility alleges the correction of the above deficiencies and the presence of ongoing quality assurance to ensure that continuing compliance with these regulations will be maintained. It is understood that MDCH/BHS reserves the right to determine if the evidence submitted verifies compliance and to visit the facility at any time to verify correction of these deficiencies. It is further understood that enforcement remedies applicable to these deficiencies may be immediately imposed if MDCH/BHS determines that the facility has not corrected these deficiencies.

Name of Administrator (Please Print) _____

Administrator's Signature: _____ Date: _____

For MDCH/BHS: This evidence has been determined to be: acceptable not acceptable
evidence of compliance.

The effective date of compliance is: _____ .

CIU Manager Signature: _____ **Date:** _____